CONNECTICUT ASSOCIATION FOR
HEALTHCARE AT HOME

TESTIMONY

Delivered by Tracy Wodatch, President and CEO
The Connecticut Association for Healthcare at Home

Before the Public Health Committee

February 27, 2023

SB 1075: AN ACT CONCERNING HOSPICE AND PALLIATIVE CARE
SB 1076: AN ACT CONCERNING AID IN DYING FOR TERMINALLY ILL PATIENTS

Senator Anwar, Representative McCarthy Vahey and distinguished members of the Public Health Committee, my name is Tracy Wodatch, President and CEO of the Connecticut Association for Healthcare at Home. I am also an RN with 40 years' experience in home health, hospice, long-term and acute care.

The CT Association for Healthcare at Home is the united voice for 22 of the 25 hospice providers in Connecticut, all of whom are Licensed by DPH, Certified by Medicare. Our membership includes highly qualified, dedicated hospice provider experts who care for those facing terminal illness along with their families.

The Association has grave concerns about SB 1075, a bill looking to create a hospital at home hospice pilot program as that level of care already exists within the hospice Medicare benefit. I have included with my testimony a flier that outlines the four levels of hospice care, two of which are offered in the home, Routine Home Care and Continuous Home Care or CHC.

This bill mostly describes the existing CHC level of care which is "care provided in the home between 8 and 24 hours per day to manage uncontrolled pain and other acute medical symptoms. CHC care must be predominantly nursing care supplemented with caregiver and hospice aide services and is intended to maintain a patient at home during a pain or symptom crisis. It includes a physician or APRN driven plan of care with nursing, social work, pastoral care, hospice aide, medical equipment, medications and follow up bereavement/grief counseling.

If there is something specific the committee is looking to address with current hospice care in CT, the Association would be happy to work with you, but this bill replicates what already exists.

Regarding SB 1076 Aid in Dying, our Association and its hospice providers are committed to the hospice philosophy cherishing life until its natural end while reinforcing dignity, quality and comfort for both the patient and their loved ones. We do not support or oppose Aid in Dying as it is a personal choice.

However, after reading SB 1076, I am pleased to see each year this bill is raised, more of our recommendations are included. Additions this year include a referral for counseling to ensure competency, a change in CT residency timeframe, more protections for the unused medication and for minimizing abuse of the law, as well as a follow up by the physician every 30 days after prescribing the medication.

We remain concerned about the following and offer suggestions:

- The definition of hospice, while present, is sorely lacking and should be more aligned with the descriptive definition of palliative care.
- Self-administration needs to include ability to **prepare** and ingest the medication. No one should assist the patient with this process.
- The word "physical" should be removed from definition of Terminal Illness.
- RNs, who pronounce death in the home and complete the death certificate, need more instruction. What to do at 2am in the patient's home?
- Add language to include unused medication is often destroyed in the home per DCP instructions and federal law.

What continues to be missing is a statewide Policy/Education Task Force to help guide policy development and educational support which we still strongly support and ask to be included.

Thank you and we are happy to work with the committee on amendments for 1076 as outlined. If you have any further questions, please contact me directly at Wodatch@cthealthcareathome.org or 203-774- 4940.

CONNECTICUT ASSOCIATION FOR HEALTHCARE AT HOME™

The Connecticut Association for Healthcare at Home is the industry champion for quality, cost-effective home health, hospice, and community based solutions.

MEDICARE HOSPICE LEVELS OF CARE

Hospice patients may require different intensities of care during the course of their final stages of their disease. The Medicare Hospice Benefit* affords patients, with a prognosis of less than six months, four levels of hospice care to meet their clinical needs: (see below.) Payment for each covers all aspects of the patient's care related to the terminal illness, including all services delivered by the Interdisciplinary team, medication, medical equipment and supplies. While hospice patients may be admitted at any level of care, the progression of their illness may require a change in their level of care.

MOST COMMON

LEAST COMMON

ROUTINE HOSPICE CARE (RHC)

RHC is the most common level of hospice care. With this type of care, an individual has elected to receive hospice care at their residence/home, which can include a private residence/home, assisted living facility or nursing facility.

CRISIS CARE

GENERAL INPATIENT CARE (GIP)

GIP is provided for pain control or other acute symptom management that cannot feasibly be provided in any other setting. GIP begins when other efforts to manage symptoms have been ineffective. GIP can be provided in a Medicare certified hospital, hospice inpatient facility, or nursing facility that has registered nursing available 24 hours a day to provide direct patient care. It is the individual needs of the patient (not the location of care or caregiver breakdown) that determines if patient qualifies for GIP level of care. A patient who is actively dying is not, in and of itself, a reason for GIP.

CRISIS CARE

CONTINUOUS HOME CARE (CHC)

CHC is care provided in the home between 8 and 24 hours a day to manage uncontrolled pain and other acute medical symptoms. CHC services must be predominately nursing care, supplemented with caregiver and hospice aide services and are intended to maintain the terminally ill patient at home during a pain or symptom crisis.

INPATIENT RESPITE CARE

Inpatient Respite Care is available to provide temporary relief to the patient's primary caregiver. Respite care can be provided in a hospital, hospice facility, or a long-term care facility that has sufficient 24-hour nursing personnel present on all shifts to guarantee that patient's needs are met. Respite care is provided for a maximum of 5 consecutive days.

For Commercial Insurance, refer to the carrier's policy for hospice coverage.

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